Chapter 7

Court-Dependent Children

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Editor's Note: This chapter was contributed by two mental health professionals with extensive forensic experience conducting court-ordered evaluations of children in juvenile dependency proceedings. It reflects a mental health perspective on working with children involved with both Public Child Welfare and the Juvenile Court.

Introduction

Society's response to child victims of trauma involves systems and persons well beyond the health care system. If a crime has been committed, law enforcement investigates. In many cases, public child welfare services must make a judgment about the safety of a child in the home environment. The Juvenile Dependency Court may declare the child a Dependent of the Court and make an appropriate disposition ranging from supervised parental custody to removal from the home. A child may go to live with relative caregivers or foster parents. A child trauma victim is a potential witness in the court systems, and may even testify against a parent or other family member. A foster care placement may evolve from a temporary resource into long-term placement or even adoption. Children may have the task of forming collateral attachment relationships with new primary caregivers at the same time that they are experiencing the loss of relationships in their own families.

A mental health professional who provides services to Dependent Children of the Court must develop an understanding and appreciation of the roles of persons from many agencies and institutions, because those persons and their decisions have a significant impact on the management of mental health treatment. This chapter focuses on how the Juvenile Court (Dependency Branch) and the public child welfare system interact with and influence the mental health services provided to child trauma victims. It is written from the perspective of the mental health treatment provider.

Contact with Child Welfare Workers

When children are made Dependents of the Court, the Court takes legal jurisdiction over many aspects of their lives. The Court delegates some of that authority to the child welfare system, which is charged with ensuring that the children are placed in a safe environment and that their day-to-day physical and emotional needs are met as well as reasonably possible. Child Welfare Workers (CWWs) are the main link between Dependent Children of the Court and their biological parents.

The CWW is an essential resource for acquiring case information, medical and educational history, and other documentation about the child. The initial contact with the CWW provides an opportunity to establish a positive working relationship. It may be helpful to explain that you are seeking information to assist in developing a mental health treatment plan. It is important to discuss the CWW's expectations regarding the timing and format of progress reports. Ask that you be sent a copy of any Court Order regarding treatment, so that you can ensure your compliance. The Court Order is also important to establish consent for treatment and authorization to release information. The therapist should not assume that a relative caregiver or non-relative foster parent has legal standing to authorize the child's treatment. For more information, see the "Legal Issues" chapter.

Court Orders often provide information regarding the Court's overall treatment requirements (for example, sexual abuse programs, parenting classes, conjoint or family therapy) that are to occur concurrently with the treatment you are providing. Ask the CWW for the current status of the case, and what issues and decisions

about the child the Court will consider at the next hearing. The Court may have ordered independent medical or psychological evaluations (Section 730 of the California Evidence Code) of the child or other involved parties that could be useful in understanding the family dynamics. These evaluations can be useful in treatment planning and the CWW can assist the therapist in procedures for obtaining them. The CWW may also be willing to forward a copy of their last court report as a summary of the presenting issues. The documents you receive are at the discretion of the CWW, and policies regarding their release to treatment providers can vary from county to county. Sometimes it is necessary to accept verbal descriptions of a child's case history or legal status. However, you should always request copies of Court Orders related to the child's case. Court Orders regarding mental health treatment establish the legal parameters of your professional relationship with the child.

The CWW usually has specific information about the abuse suffered by a child, as well as separations, placements, and other events that may affect a child at the time of the first session. If the therapist obtains this information from the CWW, they do not have to ask the child to talk about anxiety-laden material before a therapeutic relationship has been established. During initial sessions, the therapist can reduce the child's anxiety regarding disclosure by letting the child know that the therapist has much of the information the child has already given to others. This does not mean that the traumatic event will not have to be talked about in therapy; it means that it does not have to be talked about in the initial session(s) unless the child wants to. It also means that the child does not have to guess about what the therapist knows and does not know. Reviewing the main facts of the case also allows the therapist to establish for the child that the focus of psychotherapy is the abuse they suffered and the consequences that followed. All of these things can be done more expediently and with less stress to vulnerable children by obtaining and making use of information provided by the CWW.

Attorneys

Sometimes the Court assigns dependent children their own attorney who does not represent anyone else in the case (not even the child welfare agency). When a child has their own attorney, the treating therapist should initiate contact with them and keep them apprised of the child's general treatment progress and well being. The opinion of the children's attorney will be given considerable weight by the Court in matters pertaining to the child. As a general rule, children's attorneys have the best interests of their child client as their primary concern. The situation may be more complicated for attorneys who also represent a child welfare agency or other parties in the case.

Relative Caregivers and Foster Parents

The initial interview with the child's current caregiver provides basic information about the child's daily routines, adjustment to foster care, and observable emotional and behavioral problems. Depending on how well the caregiver knows the child, they may be able to provide information about the victimization, the professionals involved, and how long the child has been separated from the alleged offender(s). However, it is not unusual for a non-relative foster parent to have minimal information about the child or the circumstances that placed them in foster care.

During the initial interview, the therapist should discuss with the caregiver the following topics:

- Procedures relating to consent for the child's treatment
- Services to be provided
- Mandated reporting requirements concerning child abuse and neglect
- Issues of confidentiality and privilege
- Procedures for billing and reimbursement

When treating a Dependent Child of the Court, the therapist must clearly inform the child's caregiver that there are limits to treatment confidentiality and privilege when the Court has ordered the treatment.

Typically, the therapist is expected to provide verbal or written reports about the child's treatment progress to the CWW and the child's attorney. Reimbursement sources may also require information. The therapist must obtain written authorization to release information from the holder of the child's privilege in order to provide information to these persons. For more information, see the Ethics and Legal chapters.

The CWW is likely to ask the therapist to provide information and opinions regarding the child's interactions and relationships with caregivers, siblings, and family members. Relative caregivers and foster-parents should be informed that the Court typically wants to know how well the child is adjusting to foster care. In cases that may lead to long-term placement or adoption, these foster family relationships are of particular interest to the Court. If the therapist plans to evaluate the child's interactions with the relative or non-relative foster-caregivers, written authorization must be obtained from all parties.

It is important to tell the caregiver that you are gathering court-related information to aid in establishing a treatment plan. Optimally, your treatment plan should also include information from other professionals rendering services to the child, such as physicians and teachers.

Explain to the caregiver that it is crucial for the child to be able to establish a trusting relationship with the therapist in order to reveal their experiences, reactions and emotions. In addition, the caregiver's participation in the treatment process is essential for stabilizing the child's world, for supplying information about the child's progress, and for supporting the child's emotional gains. Let the caregiver know that you will be explaining to the child that a progress report will be asked of you to help the Court make decisions about the child's safety, their progress in treatment, and their readiness to repair various family relationships.

Treatment Planning with Court-Dependent Children

Therapists must anticipate the likelihood that a child's trauma recovery will be complicated by stressors that occur after the child has been traumatized. Some of those stressors, such as being placed in a foster home, testifying in court, or grieving over the loss of parents and siblings, can preempt recovery work. The worries and anxieties that children bring into therapy generally stem most acutely from the most immediate stressors in their lives. Psychotherapy with dependent children should not lose its central focus of trauma recovery, but therapists need to deal with iatrogenic traumas — traumas that are the consequence of social and legal interventions.

Iatrogenic trauma can cause symptoms of anxiety and sadness, which — although not acute enough to be labeled a mental disorder — can be chronic and pervasive enough to cause significant distress. Primary trauma behaviors are those that result from the child's initial traumatic victimization. For example, abuse-reactive behavior is a primary trauma behavior. Secondary trauma behaviors result from the emotional and behavioral problems resulting from system interventions. Worry and grief about family separation is a secondary trauma behavior. Typically, a treatment plan for a Dependent Child of the Court must include attention to both types of trauma.

With regard to treatment goals, behaviors which threaten the safety of a child, or which threaten the safety of others, should receive the highest priority. Behaviors which threaten the stability of a child's placement, or which are likely to cause estrangement from others, should also receive priority. Because so much may be at stake for dependent children, and because the time that is available for psychotherapy is limited by legal mandate, modes of treatment that are likely to produce the quickest changes are preferred. While short-term modes of treatment may not produce enduring changes, relief from unrelenting anxiety and sadness, and a reduction in behaviors that alienate others, can produce immediate benefits for the child. Therapists who were trained in traditional psychoanalytic approaches may regard a sudden lessening of symptoms in the beginning of treatment ("transference cure") as not likely to produce lasting results. With dependent children, however, even modest relief of symptoms should be welcomed and treasured. Every day of relative calm and hope that can be gained for abused children is likely to increase the odds that they can cope more successfully with secondary trauma and have the psychological resources to recover from the primary trauma.

The initial treatment plans for dependent children should be formulated in terms of behaviors that are observable and goals that are reachable within a short time. Some initial success is critical for dependent children early in therapy. Therapists may have only a few weeks before secondary trauma destabilizes a child and forces an immediate reordering of priorities. The treatment plan can be described as a series of short-term goals that are successive approximations of long-term goals. It is important to have long-term goals, but therapists for dependent children must be aware that "long-term" may be no longer than six months and that the "treatment plan" the court dictates is likely to override the therapists' treatment plan.

In the course of treatment, consultation with other professionals is often essential to facilitate the child's adjustment and to reduce symptoms. Children who are displaced from their homes and familiar settings require special attention to structure, routine and consistency by adults in their new environment. Consultations with a child's physicians, psychiatrist, teachers or other involved professionals (for example, speech or physical therapists) to exchange information can assist in stabilizing or managing the child's behavior or reactions with the goal of improving the child's level of functioning. Each professional has the task of responding to the child's presenting symptoms or needs and forming a therapeutic alliance that can support the child's psychological recovery.

Psychotherapy Issues with Dependent Children

Children cast adrift in a foster care system that cannot promise love and stability present a serious dilemma for child therapists. Therapists cannot provide such children with the emotional foundation they require to benefit optimally from therapy, but such children should not be denied access to a psychotherapist just because their needs are too great. At times, it may seem to the child's therapist that the resolution to this dilemma is to act as the unacknowledged surrogate parent for the child. Therapists may feel that they are the only sane and consistent figure in the child's life. In fact, the rescue fantasy of becoming a child's foster parent occurs at some time to almost every therapist of dependent children. Acting on these feelings can blur boundaries, confuse the focus of treatment, and undermine treatment goals. Therapists should avoid the ethical problems and role confusion that arise with dual relationships, and they must be equally aware of the risk to the child of making implicit promises of long-term care and nurturance that cannot be kept.

It is vital for therapists who are treating abused children to understand the difference between a "disclosure interview" and a "therapy session." Disclosure interviews are conducted with children to elicit the information necessary to allow an investigating agency (law enforcement or public child welfare) to decide whether it needs to take further action. While investigative interviewers may be concerned about the child's welfare, their primary goal is to determine whether the child needs the level of protection that can be afforded only by public child welfare or law enforcement agencies. For this reason, the interviewer sets the pace and structures the nature of the questions so as to elicit as much factual information as possible. In contrast, therapy sessions allow children and therapists more discretion about the pacing of the session, the topics discussed, and the nature of the interventions. Fact and fantasy are allowed to intermingle without requiring the child to make a distinction between them or requiring the therapist to determine legal facts. The overriding purpose of a therapy session is the child's recovery from the traumatic consequences of abuse.

In typical psychotherapy, the therapist is free to decide the nature of whatever interventions are made. However, dependent children are involved in a larger system that follows its own schedule of events. For example, a court hearing is required every six months for every dependent child. The timing of these events can affect a child considerably. The timing is determined by law, not by the needs of a particular child at any particular time. Furthermore, what transpires during those events (for example, court orders concerning the child) can cause a sudden reordering of whatever was unfolding in therapy in order to accommodate the Court's orders regarding the child. For example, a court-ordered change in visitation between a child and a parent can immediately push aside all other therapy concerns. Resumption of contact between a child and a parent after separation is almost certain to impact a child's feelings and behaviors. Some events can produce a crisis in therapy, such as the sudden appearance of an Adoption Worker into a child's life due to the possibility that parental rights might be terminated. Even if children are too young to fully understand the

possible consequences of new court actions, the therapist must continuously anticipate their implications and construct "what-if" scenarios to assist the child in coping with a range of possible legal outcomes. If a dependent child is in foster care, the stability of that placement must be monitored continuously because failures in placement can occur suddenly and disrupt therapy. This situation can even cause unplanned termination of therapy if a new placement decides not to continue the child's treatment with the same therapist.

It is possible for therapists to conduct effective psychotherapy with dependent children and to be a vital resource for the children (and sometimes the Court) at critical junctures. However, this requires that therapists stay informed, keep the CWW and the Court informed, and be able to adjust their treatment plans to meet the requirements of the juvenile dependency system, which are set by law and generally take precedence over a therapist's treatment plan.

To be successful, psychotherapy requires rapport between therapist and patient, along with at least a conditional belief by the patient that the therapist can be trusted – trusted to care, trusted to help, and certainly trusted to do no harm. Child trauma victims come to therapy at a disadvantage. If they have been abused by an adult, especially a trusted adult, they may be skeptical about any assurances from a therapist. Children's skepticism and vulnerability may be heightened if they are Dependent Children of the Court who recently learned that the consequence of telling difficult truths has been their removal from parents and home. Such children are understandably dubious about their therapist's good intentions. During initial treatment sessions, these children may assess their therapists just as carefully as the therapists assess them.

Therapists who treat dependent children need to be patient, because these children are likely to be slow to trust. Information that children give in the first few sessions may be carefully self-censored. Therapists can also expect that children will watch their reactions closely to see how the therapist feels about the significant people and events in the children's lives. In many cases, trusted family members have come under disturbingly intense scrutiny from the police and other adults. Children know that someone is in trouble, and it may be somebody with whom they have a primary attachment. More importantly, children may feel that it was their own words that were responsible for getting that person in trouble.

Most child abuse victims have a significant relationship with the person who caused their trauma. A primary attachment — even if anxious or insecure — may exist with the person who abused them. In such cases, it is likely that the child wanted the abusive behavior to stop, but they did not want the person who hurt them to go away. However, the child may be reluctant to express positive or ambivalent feelings toward the offender in the early stages of treatment. Children often tell therapists only about angry and hurt feelings, not just because they have such feelings but also because those particular feelings have been modeled and reinforced by adults (for example, the CWW or police officer). Children learn that anger and hurt about abuse are the most acceptable feelings to express. Initially, the therapist is just another unfamiliar adult and may seem no different to the child from a CWW or police officer.

It is important for the therapist to avoid any judgments or preconceptions about persons involved in the traumatic events. Therapists should not give anticipatory support for feelings they assume the children have. The only thing to be certain about in the beginning of therapy is that children's feelings are very likely to be ambivalent. Premature or overly vigorous support for one set of feelings may discourage children from expressing the other side of the ambivalence.

For therapists to facilitate the child's initial expression of feelings and at the same time allow them to experience and express contradictory feelings, it is important for therapists to remain as neutral as possible, much like the calm in the center of the storm. The impulse to establish quick rapport by strongly endorsing children's first and most obvious feelings should be resisted, or the therapist runs the risk of not helping children come to terms with ambivalent feelings that may be significant in their recovery process. It also undermines the therapist's ability to help a child tolerate and benefit from court-ordered visitation or contact with their caregivers.

Sexual and aggressive behaviors that are triggered by abuse (abuse reactive behaviors) often present a serious problem for children in foster placements. Many placements are lost because caregivers do not understand abuse-reactive behavior, how to talk about it, or how to set limits in a non-punishing manner. Sexualized behaviors are particularly troublesome in foster placements and group homes. Therapists can play an important role by assisting children and their caregivers to understand and cope with abuse-related sexual feelings and behavior. The most important intervention is providing caregivers with accurate information regarding normal sexual development in children, as well as the dynamics of abuse-reactive sexual behaviors. Caregivers need assistance establishing supportive household rules for sexually abused children, such as: talk about feelings but don't act them out; no sleeping with others; privacy in the bathroom and while bathing; and no play involving nudity or touching private body parts.

In summary, therapists who work with dependent children must be flexible and stay informed about the following:

- the child's legal situation
- the stability of the child's placement (especially if out-of-home placement has occurred)
- the status of the child as part of a larger system when setting short and long term goals.

The Impact of Visitation and Reunification Plans on Treatment

The laws that govern the relationship of dependent children to their family of origin have a significant impact on therapy with those children. Children become Dependents of the Court because the Court finds that at least one of the parents or caregivers in the family failed in their responsibility to keep the children safe. Sometimes the initial court orders allow a child to remain at home, provided that the parents cooperate with child welfare agency plans to make the family safer. Sometimes the Court finds that parents require services — such as drug rehabilitation and psychotherapy — which must take place before it is safe for the child to return home. In such cases, children are placed in alternative care. The alternative care arrangement can be with a family relative, if that is feasible; if not, the child is placed with a foster family. In either case, if the parents are permitted visitation with the children, the Court sets the frequency and circumstances of the visits. The child welfare agency plays an important role in providing information and recommendations on which the Court bases its decisions about visitation. Sometimes there is to be minimal or no contact between the child and parents for some period of time, until a service plan is in place and operating to the satisfaction of the Court. Any alternative placement or visitation plan can cause complications that must be considered in the child's treatment plan. The treatment plan must also take into account the fact that the court reviews the child's circumstances every six months and can make orders at subsequent hearings that change the circumstances in ways that can have major effects on therapy.

The Court is mandated to preserve the child's relationships with significant adults whenever it is safe to do so. The Court can order recontact sessions or designate that visitation must occur in the child's therapist's office. Such orders typically occur when the child has experienced an extended separation from a significant person in their life (for example, parent, grandparents, siblings) or victimization by a person whom the child trusted (such as a parent-offender). The Court is aware that contact may be distressing for the child. The child's reactions to the recontact sessions provide important information that the Court must consider in formulating future orders regarding visitation and reunification.

Therapists who make treatment plans for dependent children must be aware that the order which made the children Dependents of the Court sets in motion a legal process with a timetable which can end with the children being legally separated from their parents (termination of parents' rights) or having only token contact with their parents (long-term foster care). Little that can happen in therapy rivals the power of these events to alter the direction of children's lives. Therapists of dependent children must learn how to participate in those systems which have such a potent influence on the lives of their patients, and how to keep the Court informed about the emotional status of the child when decisions about visitation, reunification, and termination are made.

If therapists participate in the process that determines whether a child returns home, they should have meaningful contact with the child's parents, and also with the parents and child together. It is rarely possible to formulate sound opinions about a child's readiness for contact with parents based solely on information gained in individual therapy sessions.

However skilled and experienced therapists may be in evaluating a child's statements and behavior in the therapy, it should be assumed that (1) the child almost always has important feelings about the parents that are not revealed in therapy, (2) feelings that are expressed by the child about the parents are colored by impressions (often negative) that the child picks up from others, and (3) the child's recollection of life with the parents tends to selectively emphasize either the best or the worst experiences as time goes by.

Therapists who are asked to play a role in the visitation and reunification process should consider facilitating therapy sessions with the child and parent(s) together. The Court gives more weight to opinions about changes in parent-child contact if they are based on assessments of actual interaction. As a rule, judges and attorneys who are experienced in Dependency Court are cautious about accepting statements made by a child in individual therapy as the primary evidence in a decision about reunification. Exceptions may be made for older children, or when there is independent evidence that the parent is unfit. It is not ethical for a child's therapist to offer an opinion about parental fitness without meaningful direct contact with the parent(s).

In cases where there has been no contact between the child and parents since the child was removed from their home, or where there has been a significant lapse in contact, special care must be taken to assess the potential for resumption of contact. A child's therapist who is going to make a recommendation about this matter should meet with the parents to form an independent opinion about the parents capacity for resuming contact without causing a reappearance of traumatic symptoms in the child. If the parents are alleged to have been directly responsible for any of the trauma, some specific preparations are recommended for the parental interview.

As a rule, it requires more than one child-parent observation session to form a reliable opinion about the potential benefits of future visitations. There are cases in which the initial session is so traumatic for the child that it is obvious to everyone that another session is contraindicated. There should be at least three child-parent sessions before a therapist offers an opinion about continuing contact. The first session — however positive it may appear in the office — is likely to produce some disconcerting effects for the child. Increases in angry or oppositional behavior, as well as sleep disturbances, are commonly observed in children immediately following the resumption of contact. Such behaviors might be cited as evidence that the parent-child contact is harmful to the child and given as a reason for ending the contact. However, a child's emotional and behavioral reactions to the early stages of parental recontact are not always proof that the contact is detrimental. The initial contact may have re-stimulated positive aspects of the parental attachment and caused the child to act out against the parent figures in the foster placement as though they were to blame for the loss of the parent(s). The child may also be expressing displaced anger about an offending parent toward a foster parent, which can become a constructive focus of family therapy.

Therapists should proceed cautiously and gather adequate data before forming an opinion. Therapists should be aware that except in extreme cases, resumption of contact is likely to re-stimulate some elements of positive attachment, whatever else comes along with that attachment. One session is almost never sufficient for reaching an opinion. Whenever possible, an individual therapy session with the child be scheduled within a day or two after the initial child-parent visit, for the purpose of helping the child sort out the mixture of feelings that may have been stimulated by the contact with the parent.

The therapist can be instrumental in preparing and assisting the child with recontact sessions with parents or significant family members. It may be necessary to advise the Court of the expected number of sessions needed to prepare the child before such a visit should occur. Recontact sessions allow the therapist to intervene in unhealthy attachments, to place limits on specific behavior, and to reduce the detrimental effects of inappropriate interactions between the child and family members. In order to elicit a receptive response

from the child, the parent or family member must demonstrate the ability to reassure the child, to respond to the child's discomfort, and to acknowledge the events that led to the separation. Based on the case history, the therapist can suggest that the parent or family member ask the child for forgiveness, extend an apology for past behavior, or give the child some indication of their own treatment progress.

If the parent or family member has been involved in other treatment, the therapists should consult prior to recontact sessions. Conjoint therapy that includes the family participant's therapist can often facilitate the recontact process. This arrangement is particularly useful when the participant needs limits and guidance regarding their statements or behavior, freeing the child's therapist to focus on supporting and reassuring the child-client. Recontact sessions or therapeutically monitored visits provides opportunities to empower the child, heal the wounds of victimization, and identify stressors or dysfunction that remain obstacles in the relationship. The Court may be interested in the therapist's observations and opinions regarding the child's reactions and the parent or family member's responsiveness or sensitivity to the child.

The following can serve as guidelines for therapeutic recontact sessions:

- Interview the person(s) participating in the recontact session prior to their meeting with the child. If another therapist will be conducting the recontact session, find out the intention or goal of the session, which will help you prepare the child for it. When you are the therapist conducting the recontact session, the parent or family member who has been estranged from the child can describe their concerns and perceptions about the child that will assist you in establishing guidelines for the initial meeting.
- The child can be empowered to create rules or procedures for the recontact session or visit. The child can determine:
  - Where the child wants the therapist and other participants to sit.
  - What activities or toys are used during the session.
  - How the child might respond to difficult questions or requests by the parent or family member.
  - When the session will terminate
- The child can be encouraged to share whatever thoughts or feelings they wish with the parent or family member. Depending on the child, this may or may not include talking about the traumatic event or about problems in the relationship. The child should also be given permission to disagree with the therapist or visiting family member if their views conflict.

The child's level of stress, distrust or fear may be heightened by the recontact session. The child's limitations and coping mechanisms offer additional information for the therapist. The first recontact session is not the totality of a child's feelings about an estranged family member. These sessions should be considered a short-term intervention designed to strengthen the child's resilience, identify the child's range of feelings, and empower the child to voice their feelings. Such sessions can lead to an improved relationship, depending on the other party's level of sensitivity and response. Coordination with the parent or family member's therapist, if one is available, is usually necessary to the success of this process. Based on the progress made in recontact sessions, the Court may determine that monitored visits are an appropriate next step. The Court must also consider the parent or family member's progress in meeting other court requirements that are part of the case plan.

Court-Ordered Conjoint or Family Therapy

The Court makes its decisions about visitation and reunification based on the progress or fulfillment of Court-ordered treatment modalities. It is not unusual for the Court to order conjoint or family therapy (following successful recontact sessions) based on a parent's compliance with specific orders (for example, parenting classes, domestic violence classes, drug rehabilitation, sexual abuse programs, and individual therapy). The Court may order conjoint or family therapy to be conducted by the child's individual treating

therapist. The child's therapist is in a unique position to support the child during family therapy because in most cases the child trusts their therapist and has discussed victimization issues with them.

The child's therapist should inform the Court, the CWW, or the Child's Attorney if conjoint family therapy is clinically contraindicated, or if the therapist does not provide this treatment modality. The therapist can suggest that another therapist be appointed to perform the treatment, while remaining available for consultation. The child's therapist can also request additional sessions to prepare the child for family treatment, or to help the child become comfortable working with the therapist who performs conjoint family therapy. Consultation with the family therapist can facilitate an agreement about what information is shared with the child to prepare them. The child's therapist should tell the child that both therapists will talk with each other. This helps to reduce the child's anxiety and assists in a successful transition to the family treatment.

The various counseling programs ordered by the Court are designed to eliminate the problems that led to the child's abuse, with the goal of reuniting the child with the family. Conjoint or family therapy is ordered to reduce the emotional risks or anxiety for the child and to facilitate further therapeutic repair of the relationship. This treatment provides an opportunity for the child to have the emotional support of the therapist when the Court believes that an offender is prepared to take responsibility for their past behavior and to rebuild their relationship with the child.

The following recommendations are intended to facilitate conjoint therapy:

- Request the Court to order that all treating therapists on the case consult with each other regarding treatment plans and case coordination.
- Request the Court to order the adult parties in the case to meet for an interview with the child's therapist. The focus of this meeting is to learn the adults' perceptions of the abuse allegations and to assess their readiness for conjoint therapy.
- In some cases, it is beneficial for family therapy to occur with the child's therapist and the parent's therapist working together in a co-therapist arrangement.
- Request the Court to order a specific number of family therapy sessions as an assessment period to determine each party's readiness to cope with — and benefit from — conjoint therapy.
- Advise the adult(s) that the goal of the first family therapy session is to determine the child's ability to tolerate discussions about family relationships and the abuse history.
- Advise the participating adult(s) that they are not permitted to deny or minimize any of the child's statements or recollections.
- Remind all parties that you will be making suggestions to support positive interaction between parent and child and will terminate any session if the parent behaves inappropriately or is emotionally unsupportive of the child.
- The schedule of family therapy sessions should be spaced so that each party has time to participate in individual therapy between family sessions, in order to discuss reactions to the family sessions and gain support from their individual therapist.
- In some cases, it may be necessary for the conjoint treatment to be provided by someone other than the parent's or child's treating therapist.

Progress Reports and Testimony

As discussed in the chapter on the public child welfare system, the Court is required to attempt the reunification of children with their families whenever it is safe to do so. Under California State law, time limits are placed on family reunification services. Unfortunately, the pace of treatment does not always coincide with court review dates or the issues pending before the Court. Both the child's and parents'

progress in treatment becomes the focus of review hearings. In California, these hearings are held at six, twelve and eighteen months, or by additional hearings as ordered by the court. The Court is particularly interested in the CWW's progress reports, school assessments, medical, developmental and psychological assessments, as well as therapist progress reports (if ordered). Therapist progress reports should never include speculation about a child's relationships with individuals with whom the therapist has not had direct treatment contact. In most cases, progress reports are submitted to the CWW (there can be exceptions when a child's attorney or *guardian ad litem* exercises the privilege of confidentiality on the child's behalf). It is inadvisable to submit a report directly to the Court unless the Court Order or the child's attorney specifically requests you to do so. Unsolicited Court submissions are likely to be perceived as an excessive interest in the Court proceedings, a desire to promote a specific outcome, or an attempt to align with a particular parent, custodial relative, or foster parent.

When writing progress reports to the CWW it is important to include information about when the child's treatment began, its duration, frequency of sessions, and individuals included in the child's treatment. For example, the report should indicate whether the child's parent or foster parent was involved in the treatment process. Communication with other treating professionals should be described when the Court has ordered the consultations. This information is especially significant when the therapist is describing the child's reports about a family member whom the therapist has never actually observed interacting with the child. In such cases, it is outside the therapist's role to make recommendations regarding the child's relationships with that person. Ideally, the Court makes decisions regarding parental rights, custody and visitation based on information from many sources.

Therapist's progress reports to the public child welfare agency are not kept confidential from the children or adult parties discussed in the report. Frequently, writers of mental health progress reports request that their reports not be discussed with clients without professional consultation. Although this is a therapeutically sound and ethical request, it is rarely followed in the adversarial court environment. Attorneys defend their clients to the best of their ability, and this can include attempting to discredit a therapist's report. Child welfare agencies forward copies of their reports (with treatment reports attached) to their child clients based on policy guidelines (see the Public Child Welfare chapter). The treating therapist should consult with the CWW when preparing progress reports. It is usually clinically advisable to discuss the general contents of your report with the client(s) prior to its release.

Summary

Special considerations and procedures are necessary when providing treatment within the framework of a legal system designed to protect children, prosecute offenders, rehabilitate families, and reunite children with families when it is safe to do so. The patience required to accomplish this complex and collaborative task draws upon all the personal and professional resources within our field.